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A CASE OF ACCIDENTAL CONCEALED HEMORRHAGE.[1]

BY EDWARD REYNOLDS, M.D.

On March 29th, I was asked by Dr. E. L. Twombly to see with him a patient with the following history:

The night before, when eight months pregnant, she had begun to suffer moderate labor-pains, and after they had continued a few hours felt very faint; but on Dr. Twombly's arrival, shortly afterwards, she appeared in her usual health. Slight labor continued during the night, and early in the morning she again felt faint. There was at this time an external discharge of a small amount of reddish sero-sanguinolent fluid. She had been rather over-active for several days, but there was no history of any accident.

When I saw her, at about 9.30 A. M., March 29th, her face was pale and slightly drawn, and her lips considerably blanched; the pulse was very feeble, but its rapidity was only 60. I regret that I did not count it at the heart, as its character and the subsequent history leads me to think that I should have found a greater rapidity there. On palpation the uterine parietes yielded to the fingers some slight suggestion of an undue tonicity. The contour of the uterus was uniformly rounded, with the exception of a spot on the left side of the fundus, where a circular area of about six inches in diameter seemed to project slightly above the general level and to be of a softer consistency. The fetal heart was absent. On vaginal examination the cervix was found firm and resistent, not at all

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shortened; the internal os barely admitted the finger to the surface of the membranes; the head presented; no previa was felt. There was, at this time, no external bleeding.

I was inclined to make a diagnosis of the existence of an internal concealed hemorrhage, but in view of the rigidity of the cervix thought that any attempt at immediate delivery would be extremely hazardous, from the grave liability which I thought existed, that a profuse hemorrhage might start up while the os was still but partially dilated and undilatable. I recommended a policy of inaction, except in so far as it might be possible to expedite labor by cautious stretching of the os at intervals with the fingers, without ether.

I saw the patient again at one P. M. Her condition was then unchanged, except that the labor-pains were stronger and the cervix decidedly shortened. There had been no further hemorrhage.

At eleven P. M. I was again called, to find the accessory tumor larger, the patient decidedly more feeble, the uterus in a state of marked tonic contraction, the cervix spasmodically rigid, and the os about a third dilated, the membranes still unruptured. The patient was at once etherized: under ether the os became thoroughly relaxed, and was easily stretched to an almost complete dilatation by the hand. The membranes were then ruptured, and a considerable amount of liquor amnii, slightly tinged with blood, escaped. The patient was allowed to recover from her ether, and within five minutes a dead, but unmacerated, eight months' fetus was expelled from the vulva. The birth of the body was followed by the spontaneous and forcible expulsion of the placenta, with from a quart and a half to two quarts of dark clot. On examination of the uterine aspect of the placenta, it was found that small, firm clots existed in the spaces between the

cotyledons over the greater part of its surface. The mother's recovery was uninterrupted.

The history of this case, together with that of the very similar case which I reported to this Society two months ago, leads me to question somewhat the correctness of the position I have hitherto held in regard to the treatment of these most alarming accidents.

In 1891, in the course of a discussion before the American Gynecological Society upon the extremely able paper of Dr. Henry C. Coe on accidental hemorrhage during the first stage of labor, I stated my own opinion that this hemorrhage could be checked by one means and by one means only, that is, by securing contraction and retraction of the uterus after the delivery of the child, and advocated that measure for all cases where the condition of the patient is not so bad as to preclude all interference. That opinion was based not only upon my small previous experience with this rare accident, but upon the statistics of the operation previously published in the paper referred to, which is, so far as my knowledge extends, the latest statement of the experience of the profession on this subject; Dr. Coe places the general mortality at 51 per cent., the mortality under the expectant treatment at 75 per cent., and that which attends immediate delivery at 30 per cent. I am led to question whether, with regard to treatment, we are not bound to classify the cases in accordance with the severity of the symptoms and the condition of the cervix. It is theoretically possible that there may be cases in which the strength of the uterus is sufficient to keep the hemorrhage within bounds for a length of time sufficient to allow a dilatation of the os to occur, or, at least, softening of the cervix by the natural forces. Upon the other hand, no obstetrician of experience will doubt the statement that a dilatation of the rigid cervix may

well occupy sufficient time to allow the hemorrhage to become fatal if it should start up during the operation, an accident which the history of these cases shows to be not unusual.

The treatment which I should propose for myself in future cases of this desperate nature is as follows: If the hemorrhage is from the start so profuse as to occasion great distention of the uterus and an early and alarming collapse of the patient, a large majority of the women will be lost under any method of treatment; but I still believe that a prompt delivery then offers the only chance that there is for the life of the mother.

[The question of the possibility of saving such cases by the prompt performance of Porro's operation has been suggested, but the time does not seem to me ripe for more than the merest mention of this question.]

If the onset of the hemorrhage is gradual, if the initial collapse is not extremely alarming, and the progress of the hemorrhage seems to have become arrested before any extreme distention of the uterus occurs, I shall determine my choice of treatment by the condition of the cervix. If this is so rigid as to offer a prospect of extreme difficulty in its dilatation, I shall confine myself, as in this last case, to efforts at promoting the action of the natural forces by moderate dilatation of the os with the fingers, stimulation, and other measures intended to sustain the strength of the patient. But I wish to be understood that if this method of treatment is adopted, a physician competent for prompt delivery must be continuously by the bedside of the patient and ready to interfere.

If, in this latter class of cases (with limited hemorrhage and moderate collapse), the conditions are such as to warrant the belief that immediate dilatation and version will be reasonably easy, I believe that will

offer the best chance of saving the patient. The life of the mother is always so seriously endangered, and the fetus has in the past so rarely been saved, that the existence of the latter should ordinarily be left out of consideration in determining the plan of treatment which should be adopted.